State of Delaware - Quarterly Financial Reporting

FY19 Q1 Cost Analysis

December 2018

Willis Towers Watson

State of Delaware
Health Plan Quarterly Financial Reporting
FY19 Q1 Executive Summary

Summary plan information

- FY19 Q1 compared to FY18 Q1:

Summary (total)	FY19 (Q1)			FY18 (Q1)			% Change		
	Medical	Rx	Total[1]	Medical	Rx	Total[1]	Medical	Rx	Total
Total program cost ($M)	$148.3	$49.2	$198.1	$135.1	$43.9	$179.7	▲ 9.7%	▲ 12.2%	▲ 10.2%
Premium contributions ($M)[2]	$157.1	$46.87	$204.6	$157.9	$44.9	$203.5	▼ 0.5%	▲ 4.4%	▲ 0.6%
Total cost PEPY	$8,371	$2,778	$11,182	$7,749	$2,516	$10,302	▲ 8.0%	▲ 10.4%	▲ 8.5%
Total cost PMPY	$4,715	$1,565	$6,298	$4,350	$1,413	$5,784	▲ 8.4%	▲ 10.8%	▲ 8.9%
Average employees	70,854			69,762			▲ 1.6%		
Average members	125,792			124,258			▲ 1.2%		
Loss ratio	97%			88%					
Net income ($M)	$6.5			$23.8					

[1] Total program cost includes office operational expenses
[2] Includes fees for participating non-State groups

- FY19 Q1 Actual compared to Original Budget (approved in August 2018):

Summary (total)	FY19 (Q1) Actual			FY19 (Q1) WTW Budget			% Change		
	Medical	Rx	Total[1]	Medical	Rx	Total[1]	Medical	Rx	Total
Total program cost ($M)	$148.3	$49.2	$198.1	$161.2	$48.1	$209.9	▼ 8.0%	▲ 2.4%	▼ 5.6%
Total cost PEPY	$8,371	$2,778	$11,182	$9,038	$2,793	$11,867	▼ 7.4%	▼ 0.5%	▼ 5.8%
Total cost PMPY	$4,715	$1,565	$6,298	$5,021	$1,551	$6,593	▼ 6.1%	▲ 0.9%	▼ 4.5%
Net income ($M)	$6.5			($5.1)			-		

[1] Total program cost includes office operational expenses

Plan performance dashboard - key observations for total GHIP population

- IBM Watson Executive Dashboard for October 2017 - September 2018 (compared to October 2016 - September 2017) details the following trends and cost drivers:
  - Well visits increased across all age ranges; well baby visits increased 1.2%, well child visits increased 4.9%, and adult preventive visits increased 4.6% over the prior period
  - The percent of prescription drug allowed amounts attributable to specialty medications increased by 3 percentage points over the prior period to 37%; specialty drug unit cost increased 10% while utilization increased 8% over the prior period
  - Chronic condition prevalence remains well above benchmark for all top conditions; increases in prevalence for diabetes, hypertension, osteoarthritis and depression

Additional notes

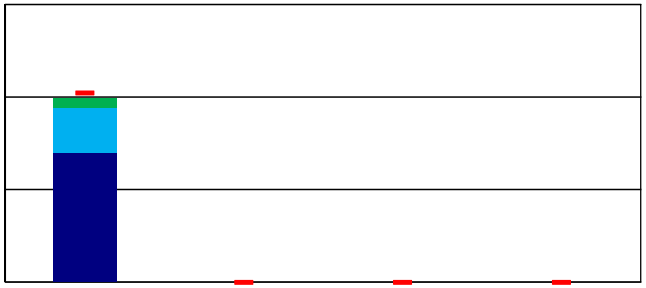
- Claims and expenses are reported on a paid basis
- Medical/Rx budget is based on FY19 budget rates, which were held flat from FY18
- Paid claims and enrollment data based on reports from Aetna, Highmark, and ESI; costs include operating expenses
- Expenses are broken down into two cateogires:
  - ASO Fees: includes fees for vendor administration, COBRA administration, ACA-related (PCORI), Truven data analytics, EAP, and WTW consulting fees
  - Office Operational Expenses: includes expenses for items such as staff salaries, supplies, etc.
- Rx rebates and EGWP payments are shown based on the period to which offsets are attributable, rather than actual payment received in a given period
- No adjustments made to cost tracking for large claims as the State does not have stop loss insurance
- HRA dollars are assumed to be included in the reported claims
- Participating groups (such as University of DE) are included in the cost tracking, but are assumed to be 100% employee paid; as a result, reported net cost and cost share percentages may be skewed

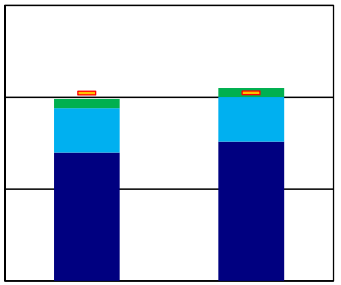
State of Delaware
Health Plan Quarterly Financial Reporting
FY19 Q1 Plan Cost Analysis

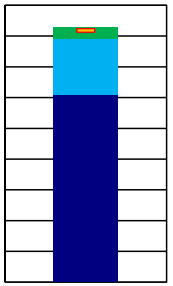
	Drop-Down Choices
Status	Total
Vendor	Total
Plan	Total

Legend

- Medical/Rx Budget
- Fees and Op. Expenses
- Rx (incl. Rebates and EGWP)
- Medical (incl. capitation)







	Q1 2019	Q2 2019	Q3 2019	Q4 2019	FY19 YTD Actual	FY19 YTD WTW Budget[6]	Difference vs. Budget	FY19 Projected[7]
Total Program Cost	**$198,069,057**				**$198,069,057**	**$209,897,858**	▼ 5.6%	**$829,394,291**
- Paid Claims	188,007,020				188,007,020	200,039,759	▼ 6.0%	790,638,732
- Medical (includes capitation[1])	139,660,686				139,660,686	151,488,322	▼ 7.8%	609,386,525
- Rx (Including Rebates and EGWP)	48,346,334				48,346,334	48,551,437	▼ 0.4%	181,252,207
- Rx Paid Claims	70,594,214				70,594,214	70,953,185	▼ 0.5%	269,078,058
- EGWP	(7,823,982)				(7,823,982)	(8,022,564)	▼ 2.5%	(32,791,519)
- Direct Subsidy	(1,171,202)				(1,171,202)	(1,214,920)	▼ 3.6%	(3,524,921)
- CGDP	(4,105,806)				(4,105,806)	(3,977,132)	▲ 3.2%	(16,378,845)
- Catastrophic Reinsurance	(2,546,974)				(2,546,974)	(2,830,512)	▼ 10.0%	(12,887,753)
- Rx Rebates[2]	(14,423,897)				(14,423,897)	(14,379,184)	▲ 0.3%	(55,034,332)
- ASO Fees	9,492,829				9,492,829	9,216,900	▲ 3.0%	36,274,934
- Operational Expenses	569,208				569,208	641,199	▼ 11.2%	2,480,626
Medical/Rx Premium Contributions[3]	**$204,602,482**				**$204,602,482**	**$ 204,799,004**	▼ 0.1%	**$818,409,929**
- Net Income	6,533,425				6,533,425	(5,098,854)		(10,984,362)
- Total Cost as % of Budget	97%				97%	102%		101%
Current Year Per Capita								
- Total per employee per year[4]	11,182				11,182	11,867	▼ 5.8%	11,706
- Total % change over prior	8.5%				8.5%			7.4%
- Medical per employee per year	8,371				8,371	9,038	▼ 7.4%	9,076
- Medical % change over prior	8.0%				8.0%			7.0%
- Rx per employee per year	2,778				2,778	2,793	▼ 0.5%	2,595
- Rx % change over prior	10.4%				10.4%			9.0%
- Medical per member per year	4,715				4,715	5,021	▼ 6.1%	5,112
- Rx per member per year	1,565				1,565	1,551	▲ 0.9%	1,462
- Total per member per year[4]	6,298				6,298	6,593	▼ 4.5%	6,593
Prior Year Results	**Q1 2018**				**Q1 2018**			**FY 2018**
- Total Program Cost	179,673,085				179,673,085	-	-	765,518,315
- Total Program Cost $ Change	18,395,972				18,395,972	-	-	63,875,977
- Total per employee per year[4]	10,302				10,302	-	-	10,902
- Medical per employee per year	7,749				7,749	-	-	8,486
- Rx per employee per year	2,516				2,516	-	-	2,380
EE Contributions[5]	**$39,772,641**				**$39,772,641**			**$159,090,565**
- Net SoD	158,296,416				158,296,416	-	-	670,303,727
- SoD Subsidy %	80%				80%	-	-	81%
Headcount								
- Enrolled Ees	70,854				70,854	70,750	▲ 0.1%	70,854
- Enrolled Members	125,792				125,792	127,350	▼ 1.2%	125,792
- Member/EE Ratio	1.8				1.8	1.8		1.8

[1] Capitation payments apply to HMO plan only

[2] Reflects estimated rebates attributable to FY19 Q1, based on WTW analysis of expected rebates under ESI contract effective July 2018 and FY18 actual rebates as of November 2018

[3] Premium contributions include fees for participating non-State groups

[4] Program cost and PEPM values also include ASO fees and operational expenses

[5] Participating groups are assumed to be 100% EE funded, and Medicare retirees are assumed to be fully subsidized

[6] WTW projected budget based on 24 months of claims experience (7/1/2016 through 6/30/2018, weighted 35% FY17 / 65% FY18), with 6.5% medical / 10% pharmacy trend (3% medical trend for Medicfill population)

[7] Projections based on most recent 12 months of claims experience (10/1/2017 through 9/30/2018)

State of Delaware
Health Plan Quarterly Financial Reporting
FY19 Q1 Reporting Reconciliation (WTW vs OMB Fund Equity Report)

FY19 YTD Reporting Reconciliation	WTW FY19 Q1 Financial Report	OMB September 2018 Fund Equity Report
Total Program Cost	**$198,069,057**	**$219,990,838**
Paid Claims	210,254,900	209,928,801
Medical Claims	139,660,686	139,998,431
Rx Claims[1]	48,346,334	69,930,370
Rx Paid Claims	70,594,214	69,930,370
EGWP	(7,823,982)	5,406,313
Direct Subsidy	(1,171,202)	1,174,183
CGDP	(4,105,806)	2,356,636
Catastrophic Reinsurance	(2,546,974)	1,875,494
Rx Rebates	(14,423,897)	14,688,653
Total Rx Claim (Offsets)/Revenue[2]	(22,247,880)	20,094,966
Total Fees	10,062,037	10,062,037
ASO Fees	9,492,829	9,492,829
Operational Expenses	569,208	569,208
Premium Contributions[3]	**$204,602,482**	**$225,084,692**
Net Income	6,533,425	5,093,854
Total Cost as % of Budget	97%	98%

[1]WTW Rx claims shown net of EGWP revenue and Rx rebates; OMB Rx claims reflect gross claim dollars excluding additional revenue (EGWP and rebates)
[2]WTW reflects EGWP revenue and Rx rebates as offsets to Rx claims; OMB reflects these items as additions to operating revenues
[3]OMB premium contributions represent total operating revenues, including premium contributions, Rx revenues (EGWP and rebates), other revenues totaling $111,088 and participating group fees totaling $533,442; WTW premium contributions represent FY19 budget rates and headcounts (net of Rx revenues), including participating group fees

State of Delaware
Health Plan Quarterly Financial Reporting
Assumptions and Caveats

Claim basis and timing

1 All reporting provided on a paid basis within this document.
2 FY2019 represents the time period July 1, 2018 through June 30, 2019 for all statuses; note Medicfill plan for Medicare eligible retirees runs from January 1, 2018 through December 31, 2018. Therefore, FY2019 financial results span two plan years for the Medicare eligible population.

Enrollment

3 Medical and Rx enrollment based on quarterly tiered enrollment data from Highmark and Aetna.
4 All Medicare eligible retirees are assumed to be enrolled in medical and Rx coverage.

Benefit costs/fees

5 Medical quarterly paid claims from Highmark and Aetna; Rx quarterly paid claims from ESI; EGWP subsidies and Rx rebates (Active, non-Medicare eligible retiree, and Medicare eligible retiree) from OMB
6 Administration fees and operational expenses from OMB-provided September 2018 Fund Equity Report as PEPM values were not provided; total quarterly fees are assigned to each plan on a contract count basis.
   a. ASO Fees: includes fees for vendor administration, COBRA administration, ACA-related (PCORI), Truven data analytics, EAP and WTW consulting fees.
   b. Operational Expenses: includes expenses for items such as staff salaries, supplies, etc.
7 Pharmacy drug rebates are shown based on the period to which rebates are attributable and reflect estimated rebates for Q1 based on prior quarters as a percentage of paid claims; active/non-Medicare eligible retiree rebates assigned to each plan on a contract count basis. May differ from actual payments received during FY2019 due to payment timing lag; these rebates reflect updated ESI contract effective 7/1/2017 following WTW independent contract analysis.
8 EGWP payments based on actual and expected payments attributable to the period July 1, 2018 through June 30, 2019; reflects estimated direct subsidy reimbursements, projected coverage gap discount payments, and estimated Calendar Year 2018 and Calendar Year 2019 catastrophic reinsurance payments from ESI (calculated by WTW). May differ from actual payments received during FY2019 due to payment timing lag.
9 Prior year costs calculated from WTW's FY18 Q4 Financial Reporting.
10 FY19 costs projected based on the most recent 12 months of data (10/1/2017 – 9/30/2018) using trend assumptions of 10.0% prescription drug, 6.5% medical for active/non-Medicare eligible retiree, 3.0% medical for Medicare eligible retiree.

Budget/contributions

11 Active and non-Medicare eligible retiree budget rates and contributions reflect rates effective July 1, 2018. Medicare eligible retiree budget rates reflect rates effective January 1, 2018 for FY19 Q1 and Q2, and rates effective January 1, 2019 for FY19 Q3 and Q4. Budget rates include FY19 risk fees for Participating groups (excludes $2.70 PEPM charge). FY19 budget rates were held flat from FY18.
12 Premiums and employee contributions are the product of monthly budget rate/contribution and quarterly average tiered contract counts provided by the medical vendors.
13 Highmark quarterly reports do not provide enrollment data split by retirement date. All Medicare eligible retirees are assumed to have retired prior to July 1, 2012, and therefore do not contribute towards the cost of premiums. As a result of this conservative assumption, the healthcare program's net cost to the State may be overstated.
14 Participating groups are assumed to be 100% employee paid in order to estimate the healthcare program's net cost to the State; actual employee contributions vary and are difficult to capture since each group pays premiums at different times.
15 While COBRA enrollment and claims are reflected in the expenses, all medical/Rx participants are assumed to pay active contributions since COBRA participants make up less than 0.1% of the total population.
16 HRA funding for CDH plans are included in the paid claims reported in this document.

State of Delaware
Health Plan Quarterly Financial Reporting
Glossary of Important Health Care Terms

Terminology	Acronym	Definition
Administrative Services Only	ASO	When an organization funds its own employee benefit plan, such as a health insurance program, and it hires an outside firm to perform specific administrative services. Also referred to as "self-funded". Currently, the GHIP has ASO contracts with Aetna, Highmark and Express Scripts.
Capitation	n/a	Fixed payment amount (per member) to a physician or group of physicians for a defined set of services for a defined set of members. Fixed or "capitated" payment per member provides physician with an incentive for meeting quality and cost efficiency outcomes, since the physician is responsible for any costs incurred above the capitated amount. May be risk adjusted based on the demographics of the member population or changes in the member population. Often used for *bundled payments* or other *value-based payments* .
Consumer Driven Health Plan	CDHP	Allows members to use health savings accounts (HSA), health reimbursement accounts *(HRA)* , or other similar medical payment products to pay routine health care expenses directly. GHIP currently offers a CDHP with *HRA* .
Coverage Gap Discount Program	CGDP	One of the funding components of an *EGWP* . Manufacturers provide discounts on covered Part D brand prescription drugs to Medicare beneficiaries while in the coverage gap.
Employee	EE	A person employed for wages or salary.
Employer Group Waiver Plans	EGWP	A Center for Medicare Service (CMS) approved program for both employers and unions. An employer may contract directly with CMS or go through an approved TPA, such as ESI, to establish the plan. They are usually Self Funded, are integrated with Medicare Part D, and sometimes include a fully insured "wrapper" around the plan to cover non-Medicare Part D prescription drugs. GHIP currently contracts with ESI as the TPA and includes a "wrapper," which is referred to as an enhanced benefit.
Fiscal Year	FY	A year as reckoned for taxing or accounting purposes. GHIP fiscal year runs from July 1st through June 30th.
Health Maintenance Organization	HMO	A form of health insurance combining a range of coverages in a group basis. A group of doctors and other medical professionals offer care through the HMO for a flat monthly rate. However, only visits to professionals within the HMO network are covered by the policy. All visits, prescriptions and other care must be cleared by the HMO in order to be covered. A primary physician within the HMO handles referrals.
Health Reimbursement Account	HRA	Employer-funded account that reimburses employees for out-of-pocket medical expenses. Employees can choose how to use their HRA funds to pay for medical expenses, but the employer can determine what expenses are reimbursable by the HRA (e.g., employers often designate prescription drug expenses as ineligible for reimbursement by an HRA). Funds are owned by the employer and are tax-deductible to the employee. GHIP only offers HRA to employees and non-Medicare eligible retirees who enroll in the CDH Gold plan.
High Cost Claimant	HCC	An insured who incurs claims over a catastrophic claim limit during the plan year. For purposes of cost tracking, this threshold is $100K.
Per Employee Per Month	PEPM	A monthly cost basis measured on an employee/contract/subscriber level
Per Employee Per Year	PEPY	A yearly cost basis measured on an employee/contract/subscriber level
Per Member Per Month	PMPM	A monthly cost basis measured on a member level
Per Member Per Year	PMPY	A yearly cost basis measured on a member level

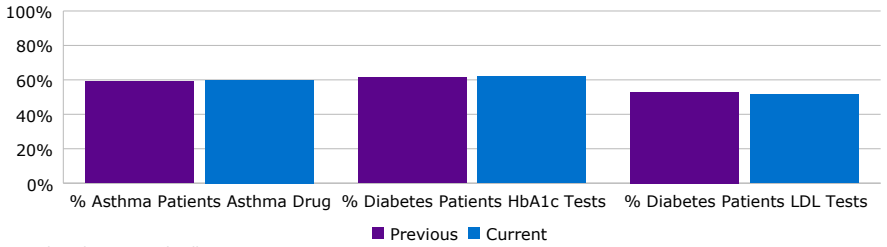
State of Delaware
Health Plan Quarterly Financial Reporting
Glossary of Important Health Care Terms

Terminology	Acronym	Definition
Patient-Centered Outcomes Research Trust Fund Fee	PCORI	The Patient-Centered Outcomes Research Trust Fund fee is a fee on plan sponsors of self-insured health plans that helps to fund the Patient-Centered Outcomes Research Institute (PCORI). The institute will assist, through research, patients, clinicians, purchasers and policy-makers, in making informed health decisions by advancing the quality and relevance of evidence-based
Point-of-Service	POS	A type of managed care plan that is a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services. GHIP only offers this type of plan to Port of Wilmington employees.
Preferred Provider Organization	PPO	A health care organization composed of physicians, hospitals, or other providers which provides health care services at a reduced fee. A PPO is similar to an HMO, but care is paid for as it is received instead of in advance in the form of a scheduled fee. PPOs may also offer more flexibility by allowing for visits to out-of-network professionals at a greater expense to the policy holder. Visits within the network require only the payment of a small fee. There is often a deductible for out-of-network expenses and a higher co-payment.
Transitional Reinsurance Fee	TRF	Fee collected by the transitional reinsurance program to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury for the 2014, 2015, and 2016 benefit years. This fee is part of the Affordable Care Act legislation, and ends after the 2016 benefit year.
Year to Date	YTD	A period, starting from the beginning of the current year (either the calendar year or fiscal year) and continuing up to the present day. For this financial reporting document, YTD refers to the time period of July 1, 2018 to September 30, 2018

Medical and Prescription Drug Dashboard - Total GHIP Population

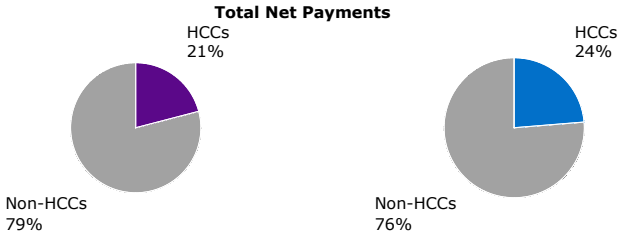
Previous Period: Oct 2016 - Sep 2017 (Paid)
Current Period: Oct 2017 - Sep 2018 (Paid)

1. Quality Metrics*



*Quality Metrics are based on Incurred Rolling Year.

2. High Cost Claimants*



*Members with >=$100,000 in Medical and Rx Net Payments

	Previous	Current	Trend
Patients	855	1,005	18%
Patients per 1,000	6.4	7.5	17%
Payments (in millions)	$160.4	$192.8	20%
Payment per Patient	$187,565	$191,813	2%

3. Well Care and Preventive Visits

	Previous	Current	Trend
Visits Per 1000 Well Baby	5,707.8	5,777.8	1.2%
Visits Per 1000 Well Child	818.1	857.8	4.9%
Visits Per 1000 Prevent Adult	388.5	406.2	4.6%

4. Medical Plan Eligibility

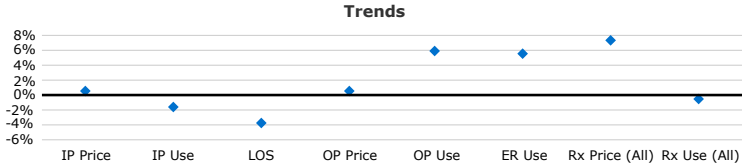
	Previous	Current	Trend
Average Employees	69,428	70,399	1%
Average Members	123,851	124,625	1%
Family Size	1.8	1.8	-1%
Member Age	42.7	42.9	0%
Members % Male	45%	45%	0% pts

5. Risk Score

	Previous*	Current**	Trend
Member Risk Score	272	279	3%

Risk score is based on the following time periods: *Previous: Jul 2016 - Jun 2017,**Current: Jul 2017 - Jun 2018

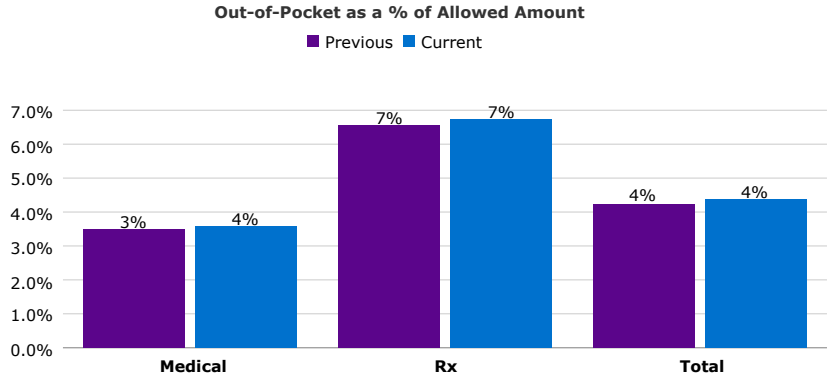
6. Price and Use



Inpatient	Current	Benchmark		Trend
Allowed per Admit	$21,541	$27,168	●	1%
Admits per 1,000	88.6	56.3	■	-2%
Days LOS	4.9	4.4	■	-4%
Outpatient				
Allowed per Service	$123	$123	◆	0%
Services PMPY	41.1	30.7	■	6%
Emergency Room Visits per 1,000	352	229	■	5%
Prescription Drugs				
Allowed/Days Supply	$2			1%
Days Supply PMPY	629			-1%
Specialty Drugs				
Allowed/Days Supply	$74			10%
Days Supply PMPY	11			8%
All Prescription Drugs				
Allowed/Days Supply	$3	$3	◆	7%
Days Supply PMPY	640	369	●	0%

● Represents a lower than -3% comparison to the benchmark
◆ Represents a comparison to the benchmark within +/-3%
■ Represents a higher than 3% comparison to the benchmark

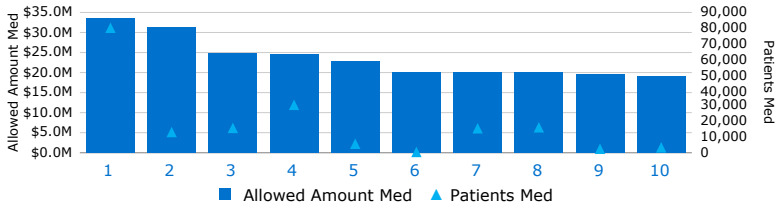
7. Cost Sharing



Medical and Prescription Drug Dashboard - Total GHIP Population

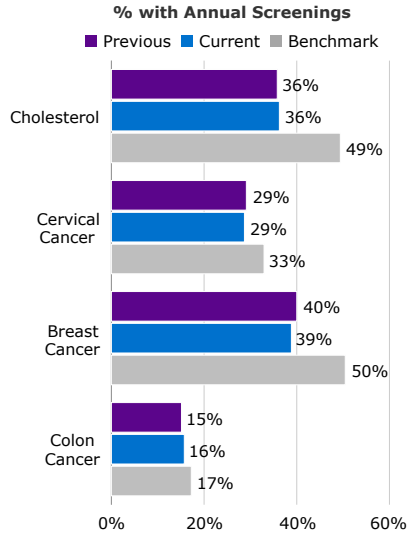
Previous Period: Oct 2016 - Sep 2017 (Paid)
Current Period: Oct 2017 - Sep 2018 (Paid)

8. Top Medical Conditions (by cost)

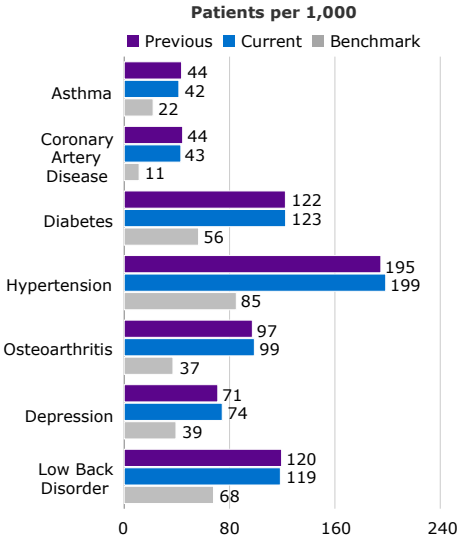


	Condition	Allowed Amount Med	Patients Med	Med Allowed /Patient
1	Prevent/Admin Hlth Encounters	$33,490,875	80,190	$418
2	Osteoarthritis	$31,396,163	13,272	$2,366
3	Spinal/Back Disord, Low Back	$24,779,333	15,923	$1,556
4	Arthropathies/Joint Disord NEC	$24,492,433	30,752	$796
5	Coronary Artery Disease	$22,792,749	5,778	$3,945
6	Chemotherapy Encounters	$20,170,141	514	$39,242
7	Respiratory Disord, NEC	$20,107,804	15,715	$1,280
8	Gastroint Disord, NEC	$20,013,746	16,321	$1,226
9	Pregnancy without Delivery	$19,490,627	2,555	$7,628
10	Renal Function Failure	$19,124,073	3,463	$5,522

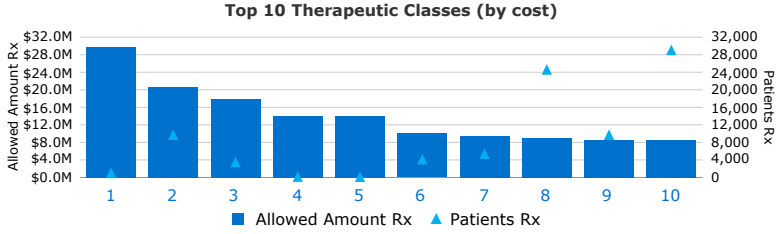
9. Screening Rates



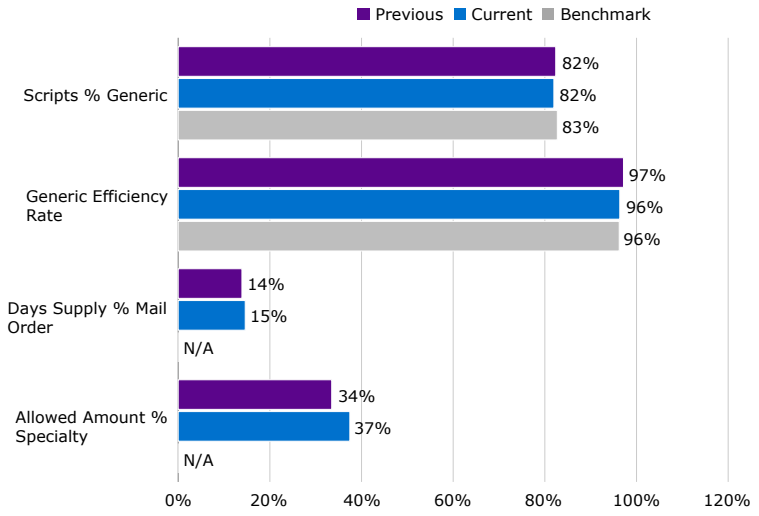
10. Chronic Condition Prevalence



11. Prescription Drug Metrics



	Therapeutic Class	Allowed Amount Rx	Patients Rx	Rx Allowed /Patient
1	Immunosuppressants, NEC	$29,771,744	1,046	$28,462
2	Antidiabetic Agents, Misc	$20,621,235	9,741	$2,117
3	Antidiabetic Agents, Insulins	$17,835,138	3,516	$5,073
4	Biological Response Modifiers	$14,061,929	191	$73,623
5	Molecular Targeted Therapy	$14,002,722	165	$84,865
6	Coag/Anticoag, Anticoagulants	$10,037,649	4,178	$2,403
7	Stimulant, Amphetamine Type	$9,466,555	5,422	$1,746
8	Adrenals & Comb, NEC	$9,095,353	24,648	$369
9	Antivirals, NEC	$8,631,163	9,755	$885
10	Antihyperlipidemic Drugs, NEC	$8,482,725	29,102	$291



Medical and Prescription Drug Dashboard - Total GHIP Population

Dashboard Glossary

General

- **Claims** are completed for claims incurred but not yet recorded (IBNR)
- **Benchmark** represents 2016 U.S. Total MarketScan norms that are age, gender, geographic, and/or severity adjusted as appropriate
- **PMPY** stands for Per Member Per Year and is weighted based on the number of months a member was enrolled in medical benefits
- **Allowed Amount (Allowed)** is the amount of submitted charges eligible for payment for medical and prescription drug claims; it is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts
- **Net Payment (Payment)** is the net amount paid by the company for medical and prescription drug claims; it represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted
- **Inpatient (IP)** represents claims for services provided under medical coverage in an acute inpatient setting; acute inpatient settings include inpatient hospitals, birthing centers, inpatient psychiatric facilities, and residential substance abuse treatment facilities
- **Outpatient (OP)** represents claims for medical services provided in any non-inpatient setting
- **Prescription Drug (Rx)** represents any claim paid under the pharmacy benefit
- **Patients** represents any member with a claim for the service (e.g., medical or prescription drug) being reported during the time period

1. Well Care and Preventive Visits

2. High Cost Claimants

- High Cost Claimants (HCCs) are members with $100,000 or more in medical and prescription drug net payments incurred during the year
- Non-High Cost Claimants (HCCs) are members with less than $100,000 in medical and prescription drug net payments incurred during the year

3. Quality Metrics

4. Medical Plan Eligibility

- **Average Employees** represents the number of employees with medical coverage; each employee is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Average Members** represents the number of members with medical coverage; each member is counted once for each month of their eligibility, then the total is averaged across the total number of months of eligibility during the time period
- **Family Size** represents the average number of covered members per subscriber
- **Member Age** represents the average age of covered members during the year
- **Members % Male** represents the number of male members as a percent of total members

5. Risk Score

The Member Risk Score represents the DCG non-rescaled concurrent score

- The Member Risk Score is produced using the Verisk DCG® model
- This model measures the health risk of a population relative to the national average as of the time the model was developed (i.e., 100)

6. Price and Use

- **Current** represents your Price or Use rate in the Current year
- **Benchmark** represents the U.S. Total MarketScan norm for the Price or Use rate
- The **Symbol** next to the Benchmark represents your Current rate compared to the Norm
- The **Trend** represents your year-over-year trend for the Price or Use rate

7. Cost Sharing

The cost sharing percentage represents Out-of-Pocket divided by Allowed Amounts

- Out-of-Pocket represents the amount paid out-of-pocket by the member for facility, professional, and prescription drug services; this generally includes coinsurance, copayment, and deductible amounts

8. Top Medical Conditions (by cost)

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Clinical conditions include medical claims (i.e., prescription drug is not included)
- Note: The clinical condition of *Signs/Symptoms/Oth Cond, NEC* is excluded from this exhibit

9. Screening Rates

- **Cholesterol** identifies lipid screening tests for males aged 35+ years and females aged 45+ years; lipid screening tests include lipid panels, serum cholesterol tests, blood lipoprotein tests (e.g., HDL, LDL), and triglyceride tests *[source for age and gender criteria: US Preventive Services Task Force]*
- **Cervical Cancer** identifies the percentage of females aged 21 to 64 who received cervical cancer screening services *[source for age, gender, procedure, diagnosis, and revenue code criteria: NCQA HEDIS 2014]*
- **Breast Cancer** identifies the percentage of females aged 50 to 74 who received mammography services *[source for age, gender, diagnosis, procedure, and revenue code criteria: NCQA HEDIS 2014]*
- **Colon Cancer** identifies the percentage of adults aged 50 to 75 who received colon cancer screening services *[source for age, diagnosis and procedure criteria: NCQA HEDIS 2014]*

10. Chronic Condition Prevalence

- Conditions represent Truven Health Clinical Condition groupings, based on ICD-9 and ICD-10 diagnosis codes
- Chronic conditions identified based on medical claims

11. Prescription Drug Metrics

- **Therapeutic Class** represents the Redbook Therapeutic Class Intermediary
- **Scripts % Generic** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled
- **Generic Efficiency Rate** is the number of prescriptions filled with a generic drug, expressed as a percentage of all prescriptions filled that could have been filled with a generic drug
- **Days Supply % Mail Order** is the percent of all prescription days supply filled via mail order
- **Allowed Amount % Specialty** is the percent of total prescription drug allowed amounts that were for medications considered to be specialty drugs (identified using Truven Health Service Categories)